South Dakota Board of Nursing
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: (605) 362-2768 ♦ www.nursing.sd.gov

Reactivation of Inactive APRN License

Please follow instructions carefully to avoid delays in processing of your CNM, CNP, CRNA, or CNS license. If any information is incorrect, incomplete or illegible, processing may be delayed. Upon receipt of all forms and fees your application will be considered for reactivation. You will be notified in writing if additional information is required.

A CNM, CNP, CRNA, or CNS (APRN license) may request reactivation of a license which has been voluntarily placed on Inactive Status.

To **reactivate** your APRN license you must hold an active South Dakota RN license or an active multi-state compact RN license.

- If your South Dakota RN license is not active or has lapsed you must reactivate or reinstate your South Dakota RN license.

  The South Dakota Board of Nursing is a part of the ***Enhanced Nurse Licensure Compact*** (eNLC) (SDCL 36-9-98). There are new features in the provisions of the legislation of the eNLC. Licensing standards are aligned in eNLC states so all applicants for a multistate nursing license are required to meet the same standards. One of the standards is a criminal background check at the time of initial licensure.

  If you were originally licensed **prior** to July 2006 you did not have a criminal background check completed in South Dakota. In order to be eligible for a multistate license you must complete a criminal background check and declare South Dakota as your primary state of residence. Please request a criminal background check packet from the SD Board of Nursing by calling 605-362-2760 or emailing Abbey.Bruner@state.sd.us.

- If your multi-state compact license is not active, contact that state's Board of Nursing to complete requirements for reactivation or reinstatement.

To REACTIVATE your advanced practice nursing license, ***submit the following*** to the South Dakota Board of Nursing office at the address listed above:

- Completed Application to Reactivate an Inactive APRN (and RN) License form indicating license(s) to be reactivated.
- Completed Employment Verification Form
- Fee payment should be in the form of a money order or a personal check payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A $20 fee will be charged for any insufficient check written.

Fees required to reactivate both South Dakota RN license and APRN license: $115 RN reactivation fee + $95 APRN reactivation fee = **$210**
Fee required to renew South Dakota APRN license only (hold valid compact RN license with multi-state privileges): $95 APRN reactivation fee = **$95**

Once you have met licensure reactivation requirements, you will be mailed a license card that will be valid from the date of issuance to your second birthday thereafter.

South Dakota Board of Nursing
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: (605) 362-2768 ♦ www.nursing.sd.gov

Application to Reactivate an Inactive APRN (and RN) License

I request to REACTIVATE each license checked:

- ☐ SD RN License Number: _____
- ☐ CRNA License Number: _____
- ☐ CNM License Number: _____
- ☐ CNP License Number: _____
- ☐ CNS License Number:_____

Name
(Last):_____(First):_____(Middle):_____

Name
(Other):_____

Address:_____

City:_____State:_____Zip:_____

Telephone(Home):_____(Work):_____(Cell):_____

Date of Birth:_____/_____/_____ Email Address:_____
month day year

Declaration of Primary State of Residence

I declare _____ to be my primary state of residence. Primary state of residence is where you hold a driver's license, pay taxes and/or vote. This state is referred to as my "home state" under the Nurse Licensure Compact and means that it is my "declared fixed permanent and principal home for legal purposes".

The following can be used to document residency pursuant to the Compact laws and rules.

1. Driver's license with a home address.
2. Voter registration card displaying a home address.
3. Federal income tax return declaring the primary state of residence.
4. Military Form No. 2058 – state of legal residence certificate.
5. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence.

For Office Use Only:

Military / Federal Employees

A federal government/military nurse practicing exclusively in federal or military systems, need only have one license from any state or territory per U.S. federal government/military policy. A federal or military nurse who also practices in a civilian health systems is bound by the Compact law and rules.

A federal/military nurse who has proof of residency in a Compact party state may be issued a Compact license with a multi-state practice privilege. A federal/military nurse who does not have proof of residency in a Compact party state may be issued a single-state license regardless of where the nurse is residing. A military/federal nurse may not hold a multi-state license from more than one Compact state at a time.

Are you employed by the military or practicing in a Federal institution?

- ☐ **Yes**
- ☐ **No**

CNM and CNP Practice Authority Status

Collaborative agreements are not required for CNMs and CNPs that have met a minimum of 1,040 hours of licensed practice in the role of a CNM or CNP.

- ☐ Have met the minimum number of hours and am not required to have a collaborative agreement on file.
- ☐ I have not met the minimum number of required hours; I have a collaborative agreement on file with the SD Board of Nursing.
- ☐ I have not met the minimum required hours; I plan to submit a collaborative agreement. I understand I may not practice in role of CNP or CNM until this agreement is on file and approved by the Board.

Certification Information

Primary source verification of *current* certification from a Board-approved certification body specific to your area of practice is *required* to be on file with the Board office prior to your APRN license being reinstated. If you are unsure if current certification is on file contact the Board office. Photocopies of certification documents are not accepted.

- ❑ My primary source verification of current certification is already on file with the BON office.
- ❑ My primary source verification of current certification is NOT on file with the BON: I will request my certifying organization send verification directly to the SD BON office.
- ❑ CRNAs primary source re-certification verification will be monitored via NCSBN and NBCRNA's websites, no need to submit.
- ❑ I am exempt from the certification requirement. I was originally licensed as a CNP/CNM in South Dakota before June 26, 1996 or as a CNS before July 1, 1996 and have never submitted certification evidence to the Board for licensure purposes.

Compliance Information

If "YES" is answered to any of the below questions please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion / compliance with court requirements.

1.	Have you been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense, other than minor traffic violations, that have not previously been reported to the board?	❑ Yes	❑ No
2.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	❑ Yes	❑ No
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❑ Yes	❑ No
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	❑ Yes	❑ No
5.	Have you had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❑ Yes	❑ No
6.	Have you been treated for abuse or misuse of any alcohol or chemical substance since your last renewal?	❑ Yes	❑ No
7.	Are you currently enrolled in an Alternative to Discipline Program? (ie SD HPAP.)	❑ Yes	❑ No
8.	Have you experienced a physical, emotional, or mental condition that has endangered or posed a direct threat to the health or safety of persons entrusted to your care or your ability to safely practice?	❑ Yes	❑ No
9.	Do you currently owe child support arrearages in the amount of $1000 or more?	❑ Yes	❑ No

Employment and Education Information:

What type of nursing degree / credential qualified you for your first U.S. nursing license?

- ☐ Vocational / Practical Certificate Nursing
- ☐ Diploma – Nursing
- ☐ Associate Degree – Nursing
- ☐ Baccalaureate Degree – Nursing
- ☐ Master's Degree – Nursing
- ☐ Doctoral Degree – Nursing

What is your highest level of education?

- ☐ Vocational/Practical Nursing Certificate
- ☐ Diploma – Nursing
- ☐ Associate Degree – Nursing
- ☐ Associate Degree – Non-Nursing
- ☐ Baccalaureate Degree – Nursing
- ☐ Baccalaureate Degree – Non-Nursing
- ☐ Master's Degree – Nursing
- ☐ Master's Degree – Non-Nursing
- ☐ Doctoral Degree – Nursing (PhD)
- ☐ Doctoral Degree – Nursing Practice (DNP)
- ☐ Doctoral Degree – Nursing Other
- ☐ Doctoral Degree – Non-Nursing

Year of initial U.S. Licensure: _____

Country of entry-level education: _____

What is your employment status?

- ☐ **Actively employed in nursing or in a position that requires a nurse license (select one)**
  - ☐ Full-time
  - ☐ Part-time
  - ☐ Per diem
- ☐ **Actively employed in a field other than nursing (select one)**
  - ☐ Full-time
  - ☐ Part-time
  - ☐ Per diem
- ☐ **Working in nursing only as a volunteer**
- ☐ **Unemployed (select one)**
  - ☐ Seeking work as a nurse
  - ☐ Not seeking work as a nurse
- ☐ **Retired**

In how many positions are you currently employed as a nurse?

- ☐ 1
- ☐ 2
- ☐ 3 or more

How many hours do you work during a typical week in all your nursing positions?

- ☐ <10 hours
- ☐ 11-20 hours
- ☐ 21-30 hours
- ☐ 31-40 hours
- ☐ 41-50 hours
- ☐ 51-60 hours
- ☐ >60 hours

Indicate the zip code, city, state and county of your primary employer.

Zip Code: _____
City: _____
State: _____
County: _____

Identify the type of setting that most closely corresponds to your nursing practice position.

- ☐ Academic Setting
- ☐ Ambulatory Care Setting
- ☐ Community Health
- ☐ Correctional Facility
- ☐ Home Health
- ☐ Hospital
- ☐ Insurance Claims / Benefits
- ☐ Nursing Home / Extended Care / Assisted Living Facility
- ☐ Occupational Health
- ☐ Policy / Planning Regulatory / Licensing Agency
- ☐ Public Health
- ☐ School Health Services
- ☐ Other

Identify the position title that most closely corresponds to your nursing practice position.

- ☐ Advanced Practice RN
- ☐ Consultant
- ☐ Nurse Executive
- ☐ Nurse Faculty
- ☐ Nurse Manager
- ☐ Nurse Researcher
- ☐ Staff Nurse
- ☐ Other – Health Related
- ☐ Other – Non Health Related

Identify the employment specialty that most closely corresponds to your nursing practice position.

- ☐ Acute Care/ Critical Care
- ☐ Adult Health / Family Health
- ☐ Anesthesia
- ☐ Community
- ☐ Geriatric / Gerontology
- ☐ Home Health
- ☐ Maternal-Child Health
- ☐ Medical / Surgical
- ☐ Occupational Health
- ☐ Oncology
- ☐ Palliative Care
- ☐ Pediatrics / Neonatal
- ☐ Psychiatric / Mental Health / Substance Abuse
- ☐ Public Health
- ☐ Rehabilitation
- ☐ School Health
- ☐ Trauma
- ☐ Women's Health
- ☐ Other

What percent of your current position involves direct patient care?

- ☐ 0%
- ☐ 25%
- ☐ 50%
- ☐ 75%
- ☐ 100%

If unemployed, please indicate the reasons.

- ☐ Difficulty in finding a nursing position
- ☐ Disabled
- ☐ Inadequate Salary
- ☐ School
- ☐ Taking care of home and family
- ☐ Other

Formal Education

- ☐ I am not taking courses toward an advanced degree in nursing
- ☐ I am currently taking courses toward an advanced degree in nursing

Do you intend to leave / retire from nursing practice in the next 5 years?

- ☐ Yes
- ☐ No

Other states in which you have ever held a license:

Active License: _____

Inactive License: _____

List all states where **currently practicing** nursing, whether physically or electronically:

_____

_____

Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant _____ **Date** _____

SOUTH DAKOTA BOARD OF NURSING
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.nursing.sd.gov

Verification of Employment

Applicant: Complete the top section of this form then forward to your employer or former employer. This form may be duplicated for additional employment verifications. **Return completed form(s) via fax, email or mail to the South Dakota Board of Nursing.**

To obtain/retain active licensure, a nurse must provide verification of a minimum of 140 hours in a 12-month period OR 480 hours in six years of employment/volunteer work in nursing.

Please Print

Name (First): _____ (Middle): _____ (Last): _____

❒ I have been employed / volunteered as a nurse (LPN, RN, CRNA, CNM, CNP or CNS).

❒ I have not been employed as a nurse within the last six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

_____ _____
Signature of Applicant Date

This Section to be Completed by Employer
(Provide Employment Hours Within the Last 6 Years)
Note: This section cannot be Signed by the Applicant

The above-named individual is/was employed/volunteered as a nurse

From _____
Month/Date/Year
To _____
Month/Date/Year

Total hours worked in this period: _____

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

_____ _____
Signature of Agency Representative/Title Date
Who can verify/confirm number of hours employed/volunteered

Name of Employer: _____

Address of Employer: _____

Telephone: _____ Email: _____